HEALTH BENEFITS CONTINUATION FORM

PLEASE PRINT CLEARLY:

DATE:

EMPLOYEE'S NAME:

SOCIAL SECURITY NUMBER:

PROGRAM/ADMINISTRATION:

_____ I AM currently enrolled in Health Benefits and I wish to continue my coverage. My renewal contract dates are from to _____. Please issue coupons for continuation of my coverage.

_____ I AM NOT currently enrolled in Health Benefits. I understand since I did not enroll in the state health benefits plan(s) within 60 days of my **first** contract begin date, that I will not be able to enroll in any of the plans until the next Open Enrollment.

Employee's Signature _____ Date _____

Personnel Officer _____ Date _____

c:hbcont/wpd